South Dakota Family Planning
Department of Health

SOUTH DAKOTA FAMILY PLANNING PROGRAM
DEFERRED EXAMINATION INFORMED CONSENT FORM

Chart # _____

NAME _____ DATE OF BIRTH _____

LNMP _____ DATE _____

BY SIGNING THE CONSENT FOR DEFERRED EXAMINATION, I AGREE THAT:

1. I am voluntarily receiving contraceptives for_____ months without having a physical or laboratory examination. I have been told that a physical and laboratory examination must be performed prior to receiving additional hormonal contraceptive.
2. I have been told that the decision to provide me with this contraceptive method is based only on information I provide about my medical history and my family history as well as my weight and blood pressure.
3. I have been told that
   a) any condition about which I fail to inform the clinic staff, and
   b) any potential condition which might exist and could be discovered by physical and laboratory examination, will not be detected at this time as a result of my consenting to deferring my examination for 3 to 6 months.
4. I have been told that hormonal contraceptives do not protect me from sexually transmitted diseases and to the best of my knowledge I am not currently infected with a sexually transmitted disease.
5. I have been told that smoking while taking hormonal contraceptives can increase my risk of stroke, heart attack, and other vascular diseases.
6. I have been told that I will be responsible for any cost related to complications that may potentially result from using the method I choose.

Client Signature: _____ Date: _____

Based on the information provided by the client, there are no contraindications to deferring the exam.

The following method(s) was given along with instruction for use:

Hormonal Contraceptive (type) _____ Dosage _____

Spermicide (type)_____ Condoms _____Number _____

Next Family Planning appointment date and time _____

Nurse's signature and title _____ Date: _____